THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

AUG 20 2003

HEALTH AFFAIRS

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)

SUBJECT: Improving Medical Record Coding at Military Treatment Facilities

The Military Health System Strategic Plan is the Department's plan to evolve into a first-class quality healthcare organization. It is a solid blueprint that will pay dividends long into the future. Its quality theme is designed to "Ensure benchmark standards for health and healthcare are met." The important link is establishing measurable criteria for healthcare performance. However, we have not been successful in implementing its key component, medical record coding.

It has become increasingly clear that significant measures are necessary to improve our medical record coding operations and performance. This is a central concern that, left unattended, will result in adverse actions at our military treatment facilities (MTFs) that may be irreversible.

Prompt and correct medical record documentation and coding is a principal determinant in quality healthcare. It is also integral to defining population health requirements, aligning resources with operations and demand management. Coding also impacts a MTF's ability to process and obtain reimbursements. Moreover, coding and documentation that is timely, accurate, and compliant with regulatory and industry standards minimizes our litigation liability. If we do not document and code properly, there is little evidence that quality work has been performed.

It is requested the following actions be taken:

- Establish a coding compliance plan within each MTF. The plan, at a minimum, should include training and an audit plan for evaluating coding compliance,
- Incorporate external auditors as part of the compliance plan,
- Ensure that all MTFs have the appropriate coding resources available (e.g., International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - most current edition; Current Procedural Terminology (CPT), 4th Edition - most current edition),
- Ensure tools are available to assist in the correct coding of encounters (e.g., Coding Clinic for ICD-9-CM, coding assist software),
- Ensure that certified coders are available to assist in coding functions,
- Ensure that coding instructors and auditors are current in and adhere to the Department of Defense (DoD) coding guidance and coding standards in the civilian medical community,

- Use the following coding standards
    a. 100 % of all outpatient encounters, other than ambulatory procedures visits (APVs), should be coded within three business days of the encounter.
    b. 100 % of APVs should be coded within 15 days of the encounter.
    c. 100 % of inpatient records should be coded within 30 days after discharge.
    d. 100 % medical record coding accuracy.
- Include medical record coding performance in military and civilian provider performance reports.

I request your report of the implementation of these measures within 90 days from the date of this memorandum.

William Winkenwerder, Jr., MD

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force